

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 1379
76

1. PLACE OF DEATH COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>M.D.</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW WINDSOR, MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. D. 4</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>HATTIE JOSEPHINE</u> (First) <u>ADAMS</u> (Middle) (Last)		4. DATE OF DEATH <u>Feb</u> (Month) <u>13</u> (Day) <u>1951</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Mar 1 - 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ALFRED ROSENBAUM</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WEIDENER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>ERNEST ADAMS, WESTMINSTER, 2 MD.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH
Two
years11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, or office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

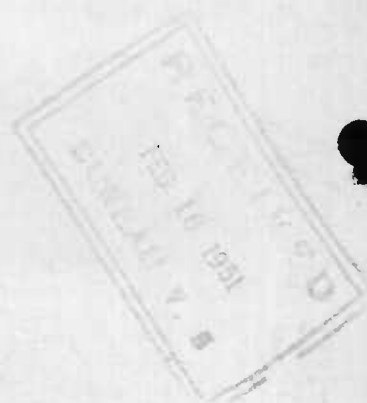
(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> LENGTH OF STAY (in this place) <u>since 3/5/49</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>609 Wildwood Parkway</u> ✓	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edgar</u> (Middle) <u>Ray</u> (Last) <u>ANDERSON</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>Jan. 26, 1894</u> 9. AGE last birthday <u>57</u> yrs. <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>John G. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Jennie High</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT AND ADDRESS <u>Records of Springfield State Hospital</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

few minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis6 yrs.(c) Syphilismore than 8 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with syphilitic meningo-encephalitis6 yrs.

19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>---</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u>		(CITY OR TOWN) <u>---</u> (COUNTY) <u>---</u> (STATE) <u>---</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>		INJURY OCCURRED <u>---</u> While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>---</u>	

22. I hereby certify that I attended the deceased from April 23, 1949, to Feb. 20, 1951, that I last saw the deceasedalive on Feb. 20, 1951, and that death occurred at 1:25 p.m., from the causes and on the date stated above.SIGNATURE Martin Gross, M.D. (Degree or title)ADDRESS Sykesville, MarylandDATE SIGNED 2/20/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/24/51</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) <u>Balt, Md</u> (State) <u>---</u>	
DATE REC'D BY LOCAL REG. <u>2/21/51</u>		REGISTRARS SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>682536 Balts-29 Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1381 76

1. PLACE OF DEATH- COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u> LENGTH OF STAY (in this place) <u>55 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL WESTMINSTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P. D. 5</u>		STREET ADDRESS (If rural, give location) <u>P. D. 5</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNIE</u>	(Middle) <u>VIRGINIA</u>	(Last) <u>BANKARD</u>
4. DATE OF DEATH	(Month) <u>FEB.</u>	(Day) <u>16</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 12-1885</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NOAH BROWN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M. GIGGARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>OLLIE J. BANKARD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Acute Coronary Thrombosis.</u>			<u>6 hours.</u>
Antecedent cause(s) (b) <u>Severe Arterio-Sclerosis -</u>			<u>10 years.</u>
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/5, 1951, to 7/16, 1951, that I last saw the deceased alive on 7/16, 1951, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE <u>Shirley Bon</u>	(Degree or title)	ADDRESS <u>Westminster, Md.</u>	DATE SIGNED <u>7/16/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>FEB 19-1951</u>	NAME OF CEMETERY OR CREMATORY <u>TRIDERS CEMETERY</u>	LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
DATE REC'D BY LOCAL REG. <u>2/16/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Address]</u>

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VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 138277

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hampstead</u> LENGTH OF STAY <u>10 yrs</u> (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hampstead</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>DELIA - F - BENSON</u>		4. DATE OF DEATH <u>Feb 15</u> 19 <u>51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov 9/1864</u>
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Aaron Bullison</u>		14. MOTHER'S MAIDEN NAME <u>Angelina Kemp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Miss Elva Benson, Hampstead</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Left Ventricular FailureINTERVAL BETWEEN ONSET AND DEATH 6 hrs

Antecedent cause(s)

(b) Arterio-Sclerotic C-V Disease3 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Carcinomatosis (Breast)4 mo.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Old Operation for Carcinoma Breast

19a. DATE OF OPERATION <u>1946</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Breast</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1946, to Feb, 1951, that I last saw the deceasedalive on Feb 15, 1951, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. C. CarterM. P.HAMPSTEAD, MD2/15/51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>Feb 18/51</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) (State) <u>Balto Co - Md</u>	
DATE REC'D BY LOCAL REG. <u>Feb 16, 1951</u>		REGISTRAR'S SIGNATURE <u>John L. Hughes, Jr.</u>		FUNERAL DIRECTOR <u>Edwin E. Hipton</u>		ADDRESS <u>Hampstead Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

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RECEIVED
FEB 19 1961
F. A. S.
NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for change
in 9 shown on:

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1283 76

FILE No. 6 1 FEB 9 1951

1. PLACE OF DEATH - COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 W. George St.</u>		STREET ADDRESS (If rural, give location) <u>16 W. George St.</u>	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Bloom</u> (Last) <u>Bloom</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>5</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 17, 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>24</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Butcher shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>David Bloom</u>		14. MOTHER'S MAIDEN NAME <u>Helena Barber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-0519</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Harold Starner Hampstead, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

433.1 Immediate cause

(a) Pulmonary Edema & Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Auricular Fibrillation

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Anuria

2 day

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	PLACE (Home, farm, factory, street, OF office bldg., etc.) _____	(CITY OR TOWN) _____	(COUNTY) _____	(STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____		

22. I hereby certify that I attended the deceased from 7/26, 1949, to 2/5, 1951, that I last saw the deceased

alive on 2/4, 1951, and that death occurred at 4:10 A. m., from the causes and on the date stated above.

SIGNATURE G. Allen Moulton M.D. (Degree or title) ADDRESS Westminster Md. DATE SIGNED 2/5/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 7, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>	LOCATION (City, town, or county) <u>near Marston, Md.</u>	(State) _____
DATE RECD BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John R. Byers</u>	ADDRESS <u>Westminster, Md.</u>	

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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1384

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Henry</u> (First) <u>Slagle</u> (Middle) <u>Brandenburg</u> (Last)		4. DATE OF DEATH <u>Feb</u> <u>28</u> <u>1951</u> (Month) (Day) (Year)	
5. SEX <u>m</u>	6. COLOR OR RACE <u>M</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 18 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, state date of retirement) <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Brandenburg</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Slagle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-03-4630</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Eugenia Brandenburg</u> <u>Sykesville Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
151x Immediate cause (a) <u>Cancer metastatic to hepatis</u>			
46b Antecedent cause(s) (b) <u>Carcinoma uterine</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct 20, 1949, to Feb. 28, 1951, that I last saw the deceased alive on Feb. 28, 1951, and that death occurred at 2 50 pm, from the causes and on the date stated above.

SIGNATURE <u>J. W. Hunter</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Sykesville, Md.</u>	DATE SIGNED <u>Feb. 28, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	LOCATION (City, town, or county) <u>Carroll Co., Md.</u> (State)
DATE REC'D BY LOCAL <u>Mar. 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Harry Keen</u>	24. FUNERAL DIRECTOR <u>C. H. Keen</u> , <u>Sykesville Md.</u> ADDRESS	

540578

MARGIN RESERVED FOR BINDING

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VS. A15

RECEIVED

MAR 7 1951

BUREAU 7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1385

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carolina</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM</u> <u>BREWINGTON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>15</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 6, 1899</u>
9. AGE last birthday <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Federalsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>	
13. FATHER'S NAME <u>Solomon R. Brewington</u>		14. MOTHER'S MAIDEN NAME <u>Alice Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Pulmonary Tuberculosis</u>		<u>April, 1950</u>
(b) Antecedent cause(s) <u>13b</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Feb. 15, 1951</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 5, 1951, to Feb. 15, 1951, that I last saw the deceased alive on Feb. 15, 1951, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

SIGNATURE <u>Elmer P. Sauer</u> M.D.		ADDRESS <u>Henryton, Maryland</u>		DATE SIGNED <u>2/15/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>Federalsburg</u>	LOCATION (City, town, or county) <u>Federalsburg, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>2/15/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Sauer</u>	24. FUNERAL DIRECTOR <u>J. Thompson</u>		ADDRESS <u>Federalsburg, Md.</u>
Deputy Local				

522358

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

1386 80

Reg. Dist. No. 2

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>New Windsor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>New Windsor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Some place</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Guy</u> (Middle) <u>ENGLAR</u> (Last) <u>CARLISLE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>4</u> 19 <u>51</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH (Specify) <u>Aug. 31, 1889</u>
9. AGE last birthday <u>61</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Carlisle</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Belle C. Carlisle (New Windsor Rural)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) —

(c) —

INTERVAL BETWEEN ONSET AND DEATH
Minutes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

New Windsor & Union Bridge, Md.
290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0

1111

RECEIVED
MAR 2 1951
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2801 W. Lanvale Street</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u> (First) <u>PAUL</u> (Middle) <u>CHRISTIE</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>12</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 2, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	9. AGE last birthday <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland/Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u>	
13. FATHER'S NAME <u>David Christie</u>		14. MOTHER'S MAIDEN NAME <u>Helen Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-01-9924</u>	
17. INFORMANT AND ADDRESS <u>Record, Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>420.0</u> <u>93d</u> <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <u>Acute and chronic myocardial infarction</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
(b) <u>Chronic arteriosclerotic heart disease with decompensation</u>		<u>indefinite</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with cerebral arteriosclerosisindefinite

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1950, to 1/12, 1951, that I last saw the deceased alive on 1/12, 1951, and that death occurred at 7:55 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-16-51</u>	REGISTRAR'S SIGNATURE <u>h</u>	24. FUNERAL DIRECTOR <u>Wm. J. Sienkiewicz & Sons - Balto.</u>	ADDRESS <u>510 246 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1388

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>State Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Montg.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> STREET ADDRESS (If rural, give location) <u>Laurel Ave</u>	
3. NAME OF DECEASED (First) <u>Margaret Emma</u> (Middle) <u>Flora</u> (Last) <u>Flora</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 17-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>56</u> yrs. If under 1 year: Months <u>7</u> Days <u>18</u> Hours <u>12</u> Min.
11. FATHER'S NAME <u>James Herberson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Louise Lynton</u>		14. BIRTHPLACE (State or foreign country) <u>Carroll Co.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT AND ADDRESS <u>Edith D. Lehman</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>Small Arterio Sclerosis</u>		<u>15 yrs</u>
giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		<u>8</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1946, to Feb 4, 1951, that I last saw the deceased alive on Feb 4, 1951, and that death occurred at 8-25 a.m., from the causes and on the date stated above.

SIGNATURE W. H. Martin M.D. (Degree or title) ADDRESS Burtonsville Md DATE SIGNED Feb 4-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union Cemetery</u>	LOCATION (City, town, or county) (State) <u>Montgomery County Md.</u>
DATE REC'D BY LOCAL REG <u>Feb 6, 1951</u>	REGISTRAR'S SIGNATURE <u>Harry Keer</u>	24. FUNERAL DIRECTOR <u>Warren E. Humphrey</u>	ADDRESS <u>8434 Ga. Ave., Silver Spring Maryland</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 15 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1389 74

1. PLACE OF DEATH- COUNTY Carroll		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY ---	
CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location) 3609 E. Elkader Road, #18	
3. NAME OF DECEASED (First) Dennison (Middle) Fox (Last) GILES		4. DATE OF DEATH (Month) Feb. (Day) 19 (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH July 1880 ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney & teaching prior to law		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 70 ? yrs. If under 1 year Months --- Days --- If under 24 hrs. Hours --- Mins. ---
11. BIRTHPLACE (State or foreign country) Burke, North Carolina		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Mark Giles		14. MOTHER'S MAIDEN NAME Julia Gibbs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT AND ADDRESS Records of Springfield State Hospital			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Chronic myocarditis and myocardial degeneration		18 days
(b) Arteriosclerosis		?
(c) ---		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis		13 yrs.
19a. DATE OF OPERATION ---	19b. MAJOR FINDINGS OF OPERATION ---	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) --- PLACE (Home, farm, factory, street, OF office bldg., etc.) --- (CITY OR TOWN) --- (COUNTY) --- (STATE) ---		
TIME (Month) (Day) (Year) (Hour) OF INJURY --- INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? ---		

22. I hereby certify that I attended the deceased from **August 1, 1949** to **Feb. 19, 1951**, that I last saw the deceased alive on **Feb. 19, 1951**, and that death occurred at **10:45 a.m.**, from the causes and on the date stated above.

SIGNATURE **Martin Gross, M.D.** (Degree or title) ADDRESS **Sykesville, Maryland** DATE SIGNED **2/19/51**

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial	DATE THEREOF Feb. 23/1951	NAME OF CEMETERY OR CREMATORY Marion	LOCATION (City, town, or county) Marion, N.C. (State) ---
DATE REC'D BY LOCAL REG. Feb. 21, 1951	REGISTRAR'S SIGNATURE C. H. Hester	24. FUNERAL DIRECTOR C. H. Hester, Sykesville, Md.	ADDRESS ---

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for addition
in 18 shown on:

2411 N. Charles Street, Baltimore

1390

CERTIFICATE OF DEATH

Reg. Dist. No. 74

FILM No. G 131 FEB 26 1951

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>3 1/2 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>Wilbur</u> (Last) <u>Hawkins</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1951</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 31, 1885</u>	9. AGE last birthday <u>65</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mental Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Julia Pope</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Elizabeth M. Hawkins - Sykesville, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardiac failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

Pneumonia, Broncho (2-21-51 - ams)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Diverticulitis of colon

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to Feb 7, 1951, that I last saw the deceased

alive on Feb. 7, 1951, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. W. Hentzen, M.D.

Sykesville, Md.

2-9-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 9 1951

C. Harry Dean

C. F. Dean - Sykesville, Md.

730869

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 14 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1391

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH - COUNTY <u>Linksbury</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Con</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Linksbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Linksbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>James Nursing</u>		STREET ADDRESS (If rural, give location) <u>Linksbury</u>	
3. NAME OF DECEASED (Type or Print) <u>Lydia</u> (First) <u>R. Ilgenfritz</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>18</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>at home</u>	8. DATE OF BIRTH <u>Aug 25 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>74</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>Wm. Gregory</u>	14. MOTHER'S MAIDEN NAME <u>Elysa De Vese</u>	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT <u>Holand C. George 3305 A Del.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
170x Immediate cause (a) <u>Carcinoma of left breast</u>			<u>many years</u>
50 Antecedent cause(s) (b) <u>metastasis to lungs -</u>			
(c) <u>Cachexia</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>arteriosclerosis -</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-1-1957</u>	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>12-1-1957</u>	
22. I hereby certify that I attended the deceased from <u>12-1-1957</u> , to <u>2-18-1957</u> , that I last saw the deceased alive on <u>2-18-1957</u> , and that death occurred on <u>2-18-1957</u> P.m., from the causes and on the date stated above.			
SIGNATURE <u>James L. Saffell M.D.</u>		DATE SIGNED <u>2-19-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>2-21-57</u>	NAME OF CEMETERY OR CREMATORY <u>Catholam</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE RECD BY LOCAL REG. <u>2/21/57</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedgcock</u>	24. FUNERAL DIRECTOR <u>W. L. Hedgcock</u>	ADDRESS <u>Home 208 Oak</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 1</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS <u>951 Penna., Ave.,</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SYLVIA</u> <u>ELIZABETH</u> <u>JACKSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 4,</u> <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb., 7, 1917</u>
9. AGE last birthday <u>33</u> yrs.		10. If under 1 year (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maid</u>	
11. BIRTHPLACE (State or foreign country) <u>Chadbourn, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Janie Randall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Lost</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pulmonary Tuberculosis</u>		<u>ay, 1950</u>
Antecedent cause(s) (b) <u>132</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 18, 1950, to Feb. 4, 1951, that I last saw the deceased alive on Febr. 4, 1951, and that death occurred at 10:15 P.m., from the causes and on the date stated above.

SIGNATURE <u>Elmer P. Sam</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Henryton, Maryland</u>	DATE SIGNED <u>2/4/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>2/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>MT. CEBURN</u>	LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>
DATE REC'D BY LOCAL REG. <u>2/4/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Swannham</u>	24. FUNERAL DIRECTOR <u>Wm. A. JACKSON - 916 PENNA. AVE</u>	ADDRESS <u>720826 Balto. 1, MD.</u>

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of #21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

FILE NO. G 131 MAR 5 1951

1. PLACE OF DEATH: COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Sykesville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location) 3036 Barclay Street (18) ✓	
3. NAME OF DECEASED (First) Edward (Middle) Eugene (Last) Kennedy		4. DATE OF DEATH (Month) Feb. (Day) 18 (Year) 19 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1/31/86 9. AGE last birthday 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman, retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Kennedy		14. MOTHER'S MAIDEN NAME Mary Mc Kewen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital records	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a) **Acute and chronic myocardial disease** 1/2 hr
 Antecedent cause(s) (b) **Hypertensive cardiovascular disease** Indefinite
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. **Intertrochanteric fracture - left femur**

12/13/50
 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) **Accident** PLACE (Home, farm, factory, street, OF office bldg., etc.) **Hospital Ward** (CITY OR TOWN) **Carroll Co. Md.** (COUNTY) **Carroll** (STATE) **Md.**
 TIME (Month) (Day) (Year) (Hour) **12-12-50** INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? **Fall by his chair. (3/5/51 - ams)**

22. I hereby certify that I attended the deceased from **10/31/50** to **2/18/51**, 19....., that I last saw the deceased alive on **2/18/51**, 19....., and that death occurred at **4:00 P.m.**, from the causes and on the date stated above.

SIGNATURE **Henry A. Mead, M.D.** ADDRESS **Sykesville Md** DATE SIGNED **2/18/51**

23. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** DATE THEREOF **2-22-51** NAME OF CEMETERY OR CREMATORY **CATHEDRAL CEM.** LOCATION (City, town, or county) **DALTON** (State) **GA.**
 DATE REC'D BY LOCAL REG. **2/20/51** REGISTRAR'S SIGNATURE **QW Hedman** 24. FUNERAL DIRECTOR **Frederick & Son** ADDRESS **Frederick & Son**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>Baltimore City Hospitals</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) (Last) <u>Moran</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>21</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/6/77</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year Months Days Hours Min. <u>19</u> <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Moran</u>		14. MOTHER'S MAIDEN NAME <u>Kate Calvary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Bilateral chronic fibrous tuberculosisIndef.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Disease11

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with cerebral arteriosclerosis. 17 mos.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/6/50, 19....., to 2/21/51, 19....., that I last saw the deceased alive on 2/21/51, 19....., and that death occurred at 6:05 P.m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Henry A. Mess M.D.2-26-51Sykesville, Md.Bald. Md.2/23/51

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Buried</u>		<u>2-26-51</u>		<u>Sykesville, Md.</u>		<u>Bald. Md.</u>		<u>2-23-51</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>2-24-51</u>		<u>C. Harry Zies</u>		<u>Leonard J. Ruch - Bald. Md.</u>		<u>Bald. Md.</u>			

970 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1395

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Union St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> STREET ADDRESS (If rural, give location) <u>19 Union St.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Henry</u> (Middle) <u>Morgan</u> (Last)		4. DATE OF DEATH <u>Feb.</u> <u>7</u> <u>1951</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 14 - 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. M. College</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year: Months <u>7</u> Days <u>7</u> Hours <u>12</u> Mins. <u>51</u>
11. BIRTHPLACE (State or foreign country) <u>Westminster Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilton Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Yuwett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Moris Morgan 19 Union St. Westminster, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
592x Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>2-5-51</u>
Antecedent cause(s) (b) <u>Myocardial (ch.)</u>			
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension (ch.)</u>			<u>2-5-51</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 2-3-, 1951, to 2-7-, 1951, that I last saw the deceased alive on 2-7-, 1951, and that death occurred at 1 P.m., from the causes and on the date stated above.

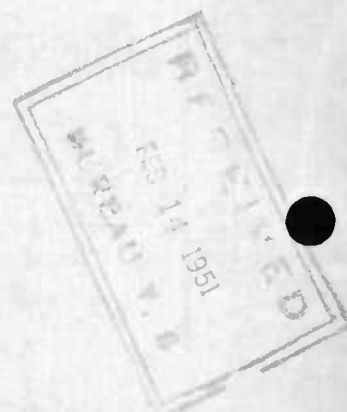
SIGNATURE W. C. Jernette Md. ADDRESS Westminster Md DATE SIGNED 2-9-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 11 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Western Chapel Cemetery</u>	LOCATION (City, town, or county) <u>Medford</u>	(State) <u>Md.</u>
DATE RECD BY LOCAL REG. <u>2/3/51</u>	REGISTRAR'S SIGNATURE <u>H. Anderson</u>	24. FUNERAL DIRECTOR <u>H. Bankard</u> ADDRESS <u>19 Union St. Westminster, Md.</u>		

754888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1396

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>1832 Druid Hill Ave.,</u>	
3. NAME OF DECEASED (First) <u>CHARLES</u> (Middle) <u>EDWARD</u> (Last) <u>OREM</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>Oct., 22, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>39</u> yrs. If under 1 year: Months <u>8</u> Days <u>9</u> If under 24 hrs: Hours <u>1</u> Min.
13. FATHER'S NAME <u>Wilmer Orem</u>		14. MOTHER'S MAIDEN NAME <u>Marie Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>219-18-2306</u>	
		17. INFORMANT AND ADDRESS <u>Mrs. Ivon Rasin-1832 Druid Hill Ave.,</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Tuberculosis</u>			<u>Nov., 1949</u>
Antecedent cause(s) (b) <u>138 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS (c) <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan., 8, 1951, to Feb., 9, 1951, that I last saw the deceased alive on Feb., 9, 1951, and that death occurred at 1:00 A. m., from the causes and on the date stated above.

SIGNATURE Elmer P. Law (Degree or title) M.D. ADDRESS Henryton, Maryland DATE SIGNED 2/9/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-13-51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)
DATE REC'D BY LOCAL REC. <u>2/9/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Savant</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Ave.</u>

Deputy Local

643 VVV Balto. Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>908 H Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>Eugene</u> (Last) <u>Owens</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Febr.</u> <u>25</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>sep.</u>	8. DATE OF BIRTH <u>6/2/91</u>
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Frank Owen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Enna Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Records of Springfield State Hosp.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause	(a) <u>Chronic myocarditis and myocardial degeneration</u>	<u>2 wks</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerosis</u>	<u>5 yrs</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Psychosis with cerebral arteriosclerosis5 yrs

19a. DATE OF OPERATION <u>---</u>	19b. MAJOR FINDINGS OF OPERATION <u>---</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>---</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Feb. 25, 1951, that I last saw the deceasedalive on Feb. 24, 1951, and that death occurred at 3, 20 a.m., from the causes and on the date stated above.SIGNATURE Martin Gross, M.D. (Degree or title)ADDRESS Sykesville, Md.DATE SIGNED 2/25/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-27-51</u>	REGISTRAR'S SIGNATURE <u>h</u>	24. FUNERAL DIRECTOR <u>Vernon Lennon</u>	ADDRESS <u>4611 Park Heights</u>	

513 VVV Balto. Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

212-07-5413

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1398 74
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u> LENGTH OF STAY (in this place) <u>since 10/9/47</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>8221 Old Georgetown Road</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>Henderson</u> (Last) <u>PETER</u>		4. DATE OF DEATH (Month) <u>Febr.</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 28, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Montgomery County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>Thomas Peter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Peter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Records - Springfield State Hospital</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerotic gangrene</u>			<u>19 days</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			<u>more than 3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senile psychosis</u>			<u>13 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>	

22. I hereby certify that I attended the deceased from March 5, 1948, to Febr. 18, 1951, that I last saw the deceased alive on Febr. 18, 1951, and that death occurred at 10,45 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D.

(Degree or title)

ADDRESS

Sykesville, Maryland

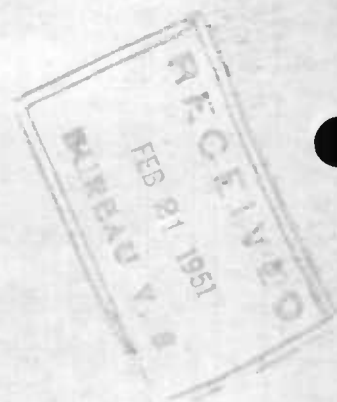
DATE SIGNED

2-18-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 22, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Ch. Cem.</u>	LOCATION (City, town, or county) <u>Washington, DC.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 19, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. Kees</u>	24. FUNERAL DIRECTOR <u>Robert A. Pumphey</u>	ADDRESS <u>Bethesda 290116 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1399
Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>16 N. Bond Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ALEXANDER</u> (First) <u>PINKNEY</u> (Middle) (Last)		4. DATE OF DEATH <u>Feb.</u> <u>8</u> <u>1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sen.</u>	8. DATE OF BIRTH <u>Aug. 27, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Loading Trucks</u>	9. AGE last birthday <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wedgefield, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willie Pinkney</u>		14. MOTHER'S MAIDEN NAME <u>Queen Ann Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>224-05-9316</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Tuberculosis</u>			<u>Mar. 1950</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 17, 1950, to Feb. 8, 1951, that I last saw the deceased alive on Feb. 8, 1951, and that death occurred at 8:40 P.m., from the causes and on the date stated above.

SIGNATURE <u>Elmer P. Samr</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>HENRYTON, MARYLAND</u>	DATE SIGNED <u>2/8/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>2/8/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Bramham</u>	24. FUNERAL DIRECTOR <u>Holland Funeral Home</u>	ADDRESS <u>1031 Union Hill Ave. 970568</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Sykesville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield St. H.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN STREET ADDRESS <u>Baughman (If rural, give location) Mrs. Thelma Watson 2437 N. Calvert St. J</u>	
3. NAME OF DECEASED (Type or Print) <u>Irene</u> (First) <u>Ward</u> (Middle) <u>Pitt</u> (Last)	4. DATE OF DEATH <u>Feb.</u> (Month) <u>2</u> (Day) <u>1957</u> (Year)		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov. 17, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pract. nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>55</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>
13. FATHER'S NAME <u>Selby H. Pritchard</u>	14. MOTHER'S MAIDEN NAME <u>Anne M. Holt</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Hosp. records</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Embolicism of lung</u>			<u>1 min</u>
Antecedent cause(s) (b) <u>Branchopneumonia</u>			<u>1 day</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis Hypertension</u>			<u>12 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Schizophrenia paranoid t.</u>			<u>12 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 1</u> , 19 <u>57</u> , to <u>Feb. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>57</u> , and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth Hinnary MD</u>		DATE SIGNED <u>Feb. 2, 57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>2/6/57</u>	NAME OF CEMETERY OR CREMATORY <u>Springfield St. H. Sykesville Md</u>
DATE REC'D BY LOCAL REG. <u>2/5/57</u>		REGISTRAR'S SIGNATURE <u>A. W. Dedrick</u>	24. FUNERAL DIRECTOR <u>Harry H. Witko 4101 Chomondale</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospt.</u>		STREET ADDRESS (If rural, give location) <u>2511 Laurretta Avenue</u> ✓	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u>	(Middle) <u>-</u>	(Last) <u>PREZIOSO</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>	8. DATE OF BIRTH <u>3/19/78</u>
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		9. AGE last birthday <u>72</u> yrs. <u>-</u> months <u>-</u> days <u>-</u> hours <u>-</u> min.	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>		13. FATHER'S NAME <u>Vincent Prezioso</u>	
14. MOTHER'S MAIDEN NAME <u>Jacqueline Primiani</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-03-0654</u>		17. INFORMANT AND ADDRESS <u>Records - Springfield State Hospital</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Bronchopneumonia

11 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Fracture of right femur

16 days

(c) ---

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senile psychosis

7 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Springfield Hospt.</u>	(CITY OR TOWN) <u>Sykesville</u>	(COUNTY) <u>Carroll</u>	(STATE) <u>Maryland</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>30</u> <u>51</u> <u>8:30</u> p.m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell out of bed</u>			

22. I hereby certify that I attended the deceased from Feb. 15, 1950. to Feb. 16, 1951, that I last saw the deceasedalive on Feb. 16, 1951, and that death occurred at 11:30 a.m., from the causes and on the date stated above.SIGNATURE Martin Gross, M.D. (Degree or title)

ADDRESS

Sykesville, Maryland

DATE SIGNED

2/16/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 20/1951</u>	<u>New Cathedral Cemetery</u>	<u>4300 Old Frederick Rd</u>	<u>Maryland</u>

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

2/19/51(Signature)Frank Della Noce322 S. High St.

590846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1402 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>45 Taney Apartments</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles</u> <u>Henry</u> <u>Price</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February</u> <u>27</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 6/1886</u>
9. AGE last birthday <u>64</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>US A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US A</u>	
13. FATHER'S NAME <u>Montgomery Price</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Pyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Hospital Records</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Arteriosclerotic Coronary disease

INTERVAL BETWEEN ONSET AND DEATH

Minutes

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

Generalized ArteriosclerosisStroke

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 30, 1951, to Feb. 27, 1951, that I last saw the deceasedalive on Feb. 27, 1951, and that death occurred at 5:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

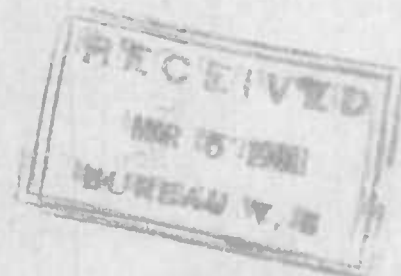
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar. 2, 1951</u>	<u>Mount Olivet</u>	<u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb. 28, 1951</u>	<u>Harry Keen</u>	<u>M. R. Echison & Son</u>	<u>Frederick, Md., 970 VVV</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



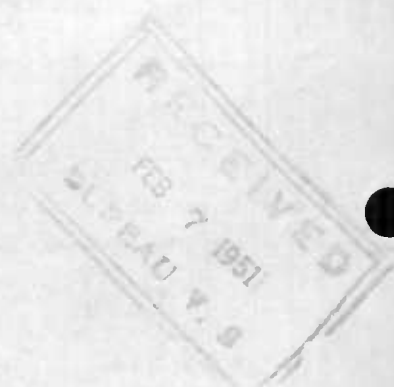
Reg. Dist. No. 74

Reg. Dist. No. 74

23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		2-8-51	Bevergreen	Berlin, Md.	2-3-51
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	ADDRESS	
2-3-51	Albert R. Frankham		Burkeage Funeral Home	Berlin, Md.	

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Baltimore, Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sykesville, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Patrick	(Middle) --	(Last) Quirk
4. DATE OF DEATH	(Month) Feb.	(Day) 3	(Year) 1951
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11/17/1870
9. AGE last birthday 80 yrs.		If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY work	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME James Quirk		14. MOTHER'S MAIDEN NAME Catherine Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. No	
17. INFORMANT Springfield State Hospital			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute heart failure	A few minutes
Antecedent cause(s) (b) Arteriosclerosis	3 yrs
(c) Schizophrenia	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	33 Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept. 1, 1947**, to **Feb. 3, 1951**, that I last saw the deceased alive on **Febr. 3, 1951**, and that death occurred at **5:40 p.m.**, from the causes and on the date stated above.

SIGNATURE **Martin Gross, M.D.** ADDRESS **Sykesville, Md** DATE SIGNED **2-4-51**

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2/7/51	NAME OF CEMETERY OR CREMATORY University Med School	LOCATION (City, town, or county) Baltimore, Md	(State)
DATE REC'D BY LOCAL REG. Feb. 7, 1951	REGISTRAR'S SIGNATURE Harry Keen	24. FUNERAL DIRECTOR Francis A. Hensley	ADDRESS 578 W. Biddle St	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

TELEPHONE ROOM

MAIL ROOM

RECORDS SECTION

TRAINING SECTION

IDENTIFICATION SECTION

LABORATORY

ADMINISTRATIVE SERVICES

COMMUNITY RELATIONS

CRIMINAL DIVISION

CIVIL RIGHTS DIVISION

INVESTIGATIVE DIVISION

LEGAL COUNSEL

OFFICE OF THE ATTORNEY GENERAL

U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

TELEPHONE ROOM

MAIL ROOM

RECORDS SECTION

TRAINING SECTION

IDENTIFICATION SECTION

LABORATORY

ADMINISTRATIVE SERVICES

COMMUNITY RELATIONS

CRIMINAL DIVISION

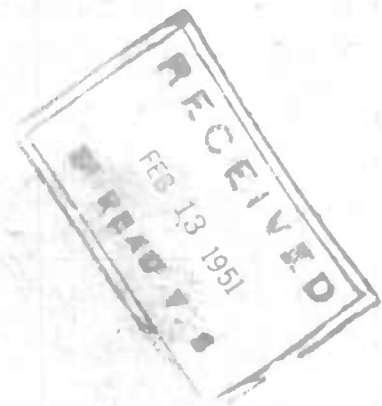
CIVIL RIGHTS DIVISION

INVESTIGATIVE DIVISION

LEGAL COUNSEL

OFFICE OF THE ATTORNEY GENERAL

U. S. DEPARTMENT OF JUSTICE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Union Bridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Union Bridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>S Main St.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Edwin</u> (Middle) <u>L.</u> (Last) <u>Seigman</u>		(Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-3-1867</u>
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Conductor</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel F. Seigman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Benner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lillian I. Seigman</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Cancer of Spine

196X Immediate cause (a)

Antecedent cause(s)

555 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 4, 1951, to Feb. 3, 1951, that I last saw the deceased alive on Feb. 3, 1951, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE OF BURIAL <u>2-6-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	LOCATION (City, town, or county) <u>Hagerstown, Wash. Co. Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 5, 1951</u>	REGISTRAR'S SIGNATURE <u>Leslie Q. Repp</u>	24. FUNERAL DIRECTOR <u>Raymond K. Wright</u>	ADDRESS <u>203506 Union Bridge Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>1200 North Eden</u>	
3. NAME OF DECEASED (First) <u>Frank</u> (Middle) <u>---</u> (Last) <u>SWICKERT</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 28, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>street cleaner, sold papers</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year: Months <u>---</u> Days <u>---</u> If under 24 hrs. Hours <u>---</u> Min. <u>---</u>
11a. FATHER'S NAME <u>Alexander Swickert</u>		11b. BIRTHPLACE (State or foreign country) <u>Prague</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		13. SOCIAL SECURITY NO. <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Anna ---</u>		15. INFORMANT AND ADDRESS <u>Records of Springfield State Hospital</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x Immediate cause (a) Cerebral hemorrhage

83a Antecedent cause(s) (b) Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ---

INTERVAL BETWEEN ONSET AND DEATH

1 day

12 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Psychosis with cerebral arteriosclerosis

5 1/2 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>---</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u>	(CITY OR TOWN) <u>---</u>	(COUNTY) <u>---</u>	(STATE) <u>---</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>		

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Feb. 15, 1951, that I last saw the deceasedalive on Feb. 15, 1951, and that death occurred at 3:30 a.m., from the causes and on the date stated above.SIGNATURE Martin Gross, M. D. (Degree or title)

ADDRESS

Sykesville, Maryland

DATE SIGNED

2/16/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Hebrew Mt Carmel</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State) <u>---</u>
DATE REC'D BY LOCAL REGISTRY <u>Feb 16 1951</u>	REGISTRAR'S SIGNATURE <u>Esther H. Hines</u>	24. FUNERAL DIRECTOR <u>Sal. Lennon & Bros - 1124-26 W.</u>	ADDRESS <u>970597 North Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1407 77

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Delaware</u> COUNTY <u>Adams</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Smydenburg Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gettysburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ANNIE</u> <u>W</u> <u>UTZ</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 13</u> <u>1951</u>	
5. SEX <u>H</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 5-1861</u>
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Utz</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cooley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year on dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Mrs Albert Houck - Westminster Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

10 days.

Antecedent cause(s)

(b)

Arterio-Sclerotic Cardiac-Renal Vascular Disease.

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 5, 1951, to Feb 13, 1951, that I last saw the deceasedalive on Feb 13, 1951, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 16/51</u>	<u>Marsh Creek</u>	<u>Adams Co.</u>	<u>Pa.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb 15-1951</u>	<u>John S. Hughes</u>	<u>Edo Chipton</u>	<u>Hampstead Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1498 75

1. PLACE OF DEATH COUNTY <u>Cornwall</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cornwall</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>North Main</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Walter</u>	(Middle) <u>W.</u>	(Last) <u>Wentz</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	4. DATE OF DEATH (Month) <u>2</u> (Day) <u>19</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rural Carrier</u>	8. DATE OF BIRTH <u>10-2-1885</u> 65 yrs.
13. FATHER'S NAME <u>John Wentz</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY No. <u>---</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bixler</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Emma Wentz</u>		<u>Manchester</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4 yrs.</u>
420.1 Immediate cause (a)	<u>Coronary Thrombosis</u>	
94a Antecedent cause(s) (b)	<u>Hypertension</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 19, 1947, to Feb 19, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 6:45 p.m., from the causes and on the date stated above.

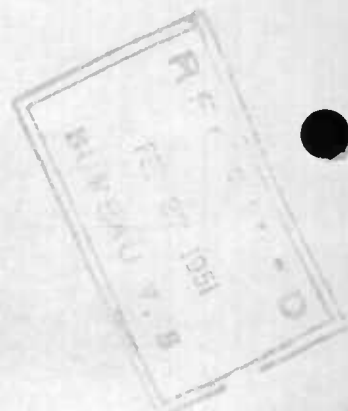
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. H. Hoard M.D. Manchester, Md Feb 20-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-22-51</u>	NAME OF CEMETERY OR CREMATORY <u>Emmanuel Lutheran</u>	LOCATION (City, town, or county) (State) <u>Manchester Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 22 51</u>	REGISTRAR'S SIGNATURE <u>Mrs. W. R. L. Danner</u>	24. FUNERAL DIRECTOR ADDRESS <u>Geo. W. Winkler Sons Manchester Md</u>	

335906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1409 78

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Taylorsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Taylorsville</u>	
TOWN <u>Taylorsville</u>		TOWN <u>Rural--Taylorsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>R.D. Westminster</u>	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>C.</u> (Last) <u>YOUNG</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-25-1869</u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer--retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	9. AGE last birthday <u>81</u> yrs. If under 1 year 12 months. If under 24 hrs. Days Hours Min.
13. FATHER'S NAME <u>Joshua Young</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary Long</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Pearl M. Young, Westminster, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>420.1</u> <u>Coronary Artery Disease</u>			<u>few minutes</u>
Antecedent cause(s) (b) <u>93d</u> <u>Cardiovascular disease</u>			<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Scurvy</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 27, 1949, to Feb. 27, 1951, that I last saw the deceased alive on Feb. 27, 1951, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

SIGNATURE <u>C. H. Billingslea, M.D.</u>	(Degree or title)	ADDRESS <u>Westminster, Md.</u>	DATE SIGNED <u>2-28-51</u>
23. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>	DATE <u>3-2-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Taylorsville</u>	LOCATION (City, town, or county) <u>Carroll Co. Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>3-1-51</u>	REGISTRAR'S SIGNATURE <u>C. M. Farver</u>	24. FUNERAL DIRECTOR <u>C. M. Waltz,</u>	ADDRESS <u>Winfield, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290116

RECEIVED
MAY 7 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH- COUNTY <u>Hampstead</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Barroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lydia</u>	(Middle) <u>Bertha</u>	(Last) <u>Zeigler</u>
4. DATE OF DEATH	(Month) <u>2</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 23, 1876</u>
9. AGE last birthday <u>74</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Greenmount, Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Martha Basley</u>	
14. MOTHER'S MAIDEN NAME <u>Annell Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>226-01-2231</u>		17. INFORMANT <u>Hellen Rittenhouse</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422, 1 Immediate cause (a) <u>Acute Ventricular Dilatation</u>		<u>12 hrs</u>
93d Antecedent cause(s) (b) <u>Arterio-sclerotic C.V. Disease</u>		<u>5 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pulmonary Edema</u>		<u>12 hrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from 7-10, 1951, to 2-13, 1951, that I last saw the deceased alive on 2-12, 1951, and that death occurred at 9 a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-16-51</u>	<u>Greenmount</u>	<u>Greenmount</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb. 15, 1951</u>	<u>John S. Hughes, Jr.</u>	<u>Jacob Wink's Sons</u>	<u>Manchester Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

